

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-033436

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9042

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1

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USE BLACK INK
OR
TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

FILED SEP 12 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. LouisLength of stay in 1b
1 Mo.c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION St. LukesX Inside Limits
Yes X No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before
a. STATE Ill. b. COUNTY Williamson (mission)c. CITY
OR
TOWN West FrankfortInside Limits
Yes ☐ No Xd. STREET
ADDRESS R. R. # 1Reside on Farm
Yes X No ☐3. NAME OF DECEASED
(Type or print)

Bessie

Middle

Last

BIEHL

4. DATE
OF
DEATH

Month

Day

Year

9

6

63

5. SEX
F6. COLOR OR RACE
W7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐8. DATE OF BIRTH
10-23-999. AGE (last birthday)
63IF UNDER 1 YEAR
Months Days Hours Min.

IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY
Home11. BIRTHPLACE (City and state or country)
Williamson Co. Ill12. CITIZEN OF WHAT COUNTRY
U S

13a. FATHER'S NAME

George Simmons

13b. MOTHER'S MAIDEN NAME

Louvenia White

14. NAME OF HUSBAND OR WIFE

Charles Biehl

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes or unknown) (If yes, give war or dates of serv)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Charles Biehl Husband

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma of Cervix

INTERVAL BETWEEN
ONSET AND DEATH

1 1/2 yrs

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

171X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)

Intestinal fistula

PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO X

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 8-6-63 to 9-6-63 and last saw her
him alive on 9-6-63
Death occurred at 8:10 PM 9-6-63 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(License or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL CREMATION,
REBURY (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Wilson Funeral Home Marion, Ill.

SEP 9 1963

Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

James L. Creason

Licensed Embalmer No. 5168

P. O. Address Millstadt, Ill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.